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SUBMISSION: INQUIRY INTO DRUGS, POISONS AND CONTROLLED SUBSTANCES AMENDMENT (PILOT MEDICALLY SUPERVISED INJECTING CENTRE) BILL 2017

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Turning Point Submission for Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017.

Turning Point welcomes the opportunity to respond to the Legal and Social Issues Committee's Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 (the inquiry).

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs and gambling, integrated with world-leading research and education. Turning Point is auspiced by Eastern Health and is formally affiliated with Monash University.

Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that:

1. Increases access to support and evidence-based practice through the use of innovative technologies.
2. Delivers high quality evidence-based practice.
3. Supports health care professionals nationally and internationally to provide high quality evidence-based practice.
4. Delivers workforce and community education programs to a broad range of populations.
5. Undertakes policy and practice relevant research and provides key national population level data.
6. Provides policy advice to state and federal governments as well as expert comment.

The inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017 requests submission to review and consider three areas:

1. Recommendations in Coroner Hawkins' Findings – Inquest into the Death of Ms A, delivered on 20 February 2017 and other relevant reports;
2. Nature and extent of current, relevant regulations;
3. And nature and extent of associated, relevant policing policy.

1. Recommendations in Coroner Hawkins' Findings

Turning Point is supportive of the recommendations made in Coroner Hawkins' Findings – Inquest into the Death of Ms A, delivered on 20 February 2017, including the establishment of a medically supervised injecting centre (MSIC) trial in North Richmond. Turning Point has consistently advocated for the introduction of evidence-based harm minimisation strategies (such as supervised injecting rooms, opiate substitution pharmacotherapy and needle and syringe programs in prisons) to tackle the reality of increasing drug hospitalisations and deaths.

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2. Nature and extent of current, relevant regulations

In 2016 alone, there were 172 heroin-related overdose deaths in Victoria, many of which occurred in the City of Yarra, concentrated around North Richmond and Collingwood. This has led to a high degree of community concern, with a growing coalition of residents, health professionals, business associations and local government calling for the introduction of a supervised injecting facility to reduce deaths. Similarly, community concern about public injecting and overdose in the Footscray area has been growing in recent years, whilst both local media and community health organisations continue to raise concerns about a paucity of drug services throughout the western suburbs more broadly.

There are currently 88 medically supervised injecting facilities operating in 58 countries internationally, including the MSIC in Sydney, which has been operating since 2001. Operating within a clinical model, the MSIC's primary objective is to reduce the morbidity and mortality associated with drug overdose. Staff include nurses who are authorised to administer naloxone. In 2010, the New South Wales Government announced it would make the MSIC an ongoing centre after three evaluations which were positive and broadly comparable with evaluation results of other similar supervised injecting drug facilities, mostly located in European cities. Among other things, the MSIC had treated a substantial number of overdoses that would otherwise have occurred in public places and without medical support, thereby effectively reducing major risks and harms to drug users and the community.

3. Nature and extent of associated, relevant policing policy

The death of Ms A and subsequent debate provoked by Coroner Hawkins' findings illuminate the fact that Australia has one of the highest rates of drug overdoses per million of population – 88.1, compared to 44.6 per million in the UK, 10.2 per million in the Netherlands and 3 per million in Portugal.[1] Coroner Hawkins' report noted that the most frequently discussed strategies to address reduction of injecting drug-related harms in the City of Yarra were:

- Needle and Syringe programs;
- Specialist outreach to engage injecting drug users;
- Naloxone distribution and peer education;
- NRCH response to heroin-related overdoes; and
- Policing.

In her findings, Coroner Hawkins observed that Victoria Police had recognized that 'NSPs (Needle and Syringe Programmes) are essential to harm reduction and consequently they do not patrol or conduct surveillance near those locations unless essential'[2]. She also noted their comment that 'Victoria Police have a long standing and recognized use of drug diversion and

[1] Source: The United Nations Office on Drugs and Crime (UNODC) '2015 World Drug Report'. www.unodc.org/wdr2015/

[2] Coroner Hawkins' findings into death of Mrs A, pp10

referral pathways for low level offenders, providing early interventions before the harms associated with drug use become more problematic'[3].

Turning Point believes that while co-operation between law enforcement and health at both national and local level has been welcomed, a national plan for addiction, along the lines of the national mental health plan would be a significant step forward in identifying gaps in the linkages between systems and ensuring that a coordinated approach to providing a continuum of care and appropriate response is possible.

A base camp for creating a national addiction strategy is the creation of evidence-based policy that demonstrates effective treatment solutions. Below is a pilot proposal that could be used as an effective means to begin delivering on Coroner Hawkins' findings from the inquest into the death of Ms A.

3.1 Pilot Proposal

If a pilot is to be established in Victoria there would be value in piloting more than one of the below approaches simultaneously in order to develop a picture of the most effective approach.

Pilots should run for a minimum of three years, with independent evaluation conducted to establish effectiveness across a range of domains, including:

- impact on opioid overdose (including ambulance call-outs, overdose presentations to emergency departments, and opioid related deaths)
- number of overdoses managed within the MSIC
- numbers of referrals to treatment and other support services
- impact on incidence, prevalence and new diagnosis of injecting drug use related blood born viruses;
- public amenity (including discarded syringe counts and community perception); and
- economic benefit.

Consultation with the local community is critical to minimise resistance and counter-productive police responses. As such, it is essential that trained addiction specialists provide expert clinical governance across the range of approaches outlined below. Establishment and maintenance of clear policies and procedures and ongoing training of staff to deliver high quality evidence-based interventions such as vein care and safer injecting advice (hygiene, filtration and sharps disposal), reproductive and sexual health advice, advice on drug treatment (including the option of initiation of opiate substitution pharmacotherapy) and other health education should be a priority. All staff should be experienced in managing mental health crises and have skills in de-escalating risky behavior.

Clinical protocols developed and overseen by the Medical Director at MSIC Sydney include providing clients with written and /or verbal referrals to relevant health and social welfare

[3] Ibid pp13

services, including drug treatment and rehabilitation programs when appropriate. Referrals are divided into three types:

1. *drug dependence treatment referrals*, which include referrals to detoxification services, opioid pharmacotherapy treatment (methadone or buprenorphine maintenance treatment), residential rehabilitation services, drug and alcohol counselling, and narcotics anonymous/self help;
2. *health care referrals*, which include referrals to medical consultations, health education services and BBV/STI testing; and
3. *social welfare referrals*, which include referrals to social welfare assistance, counselling, accommodation support and other services.

Option 1: Expand the role of existing Specialist AOD Primary Health Services (SAPH)

A number of SAPHs currently operate throughout metropolitan Melbourne:

- Innerspace, operated by cohealth on Johnston Street, Collingwood
- Healthworks, operated by cohealth on Nicholson Street, Footscray
- Living Room, operated by Youth Projects in Hosier Lane, Melbourne
- Monash Health Drug and Alcohol Service (formerly SEADS) on Foster St, Dandenong
- Access Health, operated by Salvation Army in Grey St, St Kilda
- YSAS Day Program, operated by YSAS in Langridge St, Abbotsford

Existing SAPHS operate needle and syringe programs, provide education and health promotion services, and enable people who use drugs to access comprehensive medical services. SAPHS have established relationships with many people who inject drugs, experienced and qualified staff, and in many instances operate from physical premises that could be easily modified in order to accommodate supervising injecting facilities.

SAPHs staff are experienced in engaging with people who use drugs about their drug use, education about safer drug use, managing physical and mental health issues, providing brief interventions and supporting access to treatment and other support services. These services strongly respond to the need of people using drugs within the MSIC environment and would provide a complementary service. Additionally, given that people who use drugs experience barriers to access health services, access to the SAPHs services may be increased through the MSIC pathway.

Locating a medically supervised injecting facility within an existing SAPH or SAPHs is therefore likely to be cost effective and will ensure that clients using the service can also access and benefit from a broad range of other offering, including potential referrals to treatment.

Estimated cost per SAPH: establishment cost of $300,000 + *$650,000 p.a (5 days)*
$760,000 p.a (6 days)
$900,000 p.a (7 days)

*Cost estimate based on the Innerspace service. Includes consumables; capital infrastructure/fit-out costs; staff of four (2x nurses and 2x community health workers) during an operating day of 8-10 hours per day; and management and administration overheads. **Does not include cost of supervising medical practitioner.**

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Option 2: Mobile Facility (Bus)

A number of proposals (inclusive of design work) have been developed for a mobile medically supervised injecting facility, housed within a bus that has custom fit out.

An advantage of a mobile service is for it to travel to a number of different hot spot locations, and to potentially allay any community concerns about a supervised injecting facility being 'permanently' located in their neighbourhood. This intermittent presence in a particular hotspot location may also act as a barrier to access for people who inject drugs, and the space constraints of operating the service out of a bus are likely to reduce the opportunities for longer more meaningful engagement between health workers and clients, potentially reducing the opportunities for education and referral to treatment.

Estimated cost per SAPH: establishment cost of $200,000 + *$650,000 p.a (5 days)*
$760,000 p.a (6 days)
$900,000 p.a (7 days)

*Cost estimate includes consumables; capital and running costs for the bus; staff of four (2x nurses and 2x community health workers) during an operating day of 8-10 hours per day; and management and administration overheads. **Does not include cost of supervising medical practitioner.**

Option 3: Stand Alone Fixed Site

Given the concentration of public injecting and overdose deaths in the North Richmond/Victoria Street location there is a strong argument for the establishment of a stand alone fixed site in the immediate area - such as has operated in Kings Cross in Sydney for the last 15 years. This would ensure ease of access as close as possible to the primary site of public injecting and overdose, and see the facility operating in a location where there is a high degree of local community support.

The disadvantage of this approach is that it would be the most costly of all available approaches, and it may take time to build trust with people who inject drugs and encourage them to access the centre. Furthermore, if a stand alone fixed site is being established in a location where there isn't already a SAPH operating it will be important to link the new facility with existing services in the area, and/or to establish SAPH-like services at the same location in order to ensure that people accessing the medically supervised injecting facility can also be linked in with health, support and treatment services (this may require additional funding). A fixed site will also be unlikely to impact on public injecting and/or overdose at other hotspot locations across the State, as the experience from elsewhere in the world shows that a majority of people who inject drugs will not travel across suburbs only to access a supervised injecting facility.

Estimated cost for a stand alone fixed site: $2.5-3m per annum

*Cost estimate based on the operating costs of the Sydney Medically Supervised Injecting Centre - inclusive of staffing, consumables, and infrastructure/set up costs. This estimate may vary considerably depending on property/infrastructure costs and staffing profile. **Does not include cost of supervising medical practitioner.**

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Other Considerations

1. Clearly people entering the MSIC would be in possession of illicit substances. For the pilot to be successful, Victoria Police, including members of the Drug Squad, would need to be supportive of the model and avoid surveillance of the area, which would reduce or prevent access to the target population. As with any community-based service, prompt response from Victoria Police when requested would be important for staff, client and community safety.
2. A critical success factor for the MSIC, would be the active engagement of heroin users into treatment, with enrollment in opiate pharmacotherapy a key outcome. This would require co-ordination and active linkage to local prescribers, as well as access to addiction medicine support for clients with complex presentations.

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